TRAUMA REGISTRY ADVISORY (TRAC) MEETING MINUTES
May 7, 2004

Attendees: : Kay Chicoine, John Cramer, Ginger Florechinger-Franks, Barbara Freeman, Dia Gainor, Christian Gelok, Chris Leeflang, Steve Millard, Alnita Nunnelee, Dick Schultz, Bob Seehusen, Lynette Sharp, Murry Sturkie, Leslie Tengelson

TOPIC	DISCUSSION	MOTIONS/OUTCOME/TASKS
WELCOME & INTRODUCTIONS & REVIEW MINUTES		Minutes Approved.
REVIEW PROGRESS OF RFI PROCESS AND SYSTEM COST APPROXIMATION	Christian Gelok and John Cramer reported the results of the response of six vendors to a Request for Information (RFI) distributed since the last TRAC meeting. All vendors who responded can meet all of the product requirements identified in the RFI. The next question is how we'd want the registry to be managed. Would we ask a vendor to manage the database or would Department of Health and Welfare (DHW) do the management? Two proposed business models that included four options were presented. 1) Managed by contractor a) Registry off-site managed and supported by contractor. 2) Directly Managed by DHW a) Registry on site supported by DHW. b) Registry on-site supported by contractor (third party support). c) Registry off-site supported by vendor. Dick Schultz asked whether these operating systems fit with DHW technology. The following would be the differentiating criteria: Contracted or in-house, training, support, backup systems, purchasing or leasing software, internet based (external) or in-house (internal) operation, password lock and key access.	Subcommittee formed to discuss implications and options for hospitals to shift to an internet based registry and to develop critical to quality (CTQ) requirements. Lynette Sharp will chair. The Committee suggested an RFP for a contractor to provide management, support, and selection of appropriate software. Bob Seehusen suggested that if the above subcommittee finds that a web based concept is workable for hospitals that TRAC outsource a web based program.

	The key question is who will manage the system. It is also difficult to make a choice without knowing the price tag. Note: The few base quotes received are per site. Is there an interest in outsourcing? If the costs are equal, what is DHW's preference? The Division of Health (DOH) preference would be a contractor approach because of Information Technology Systems Division (ITSD) staffing issues, loss of control about staff time and costs, and problems arising from the Department's firewalls. If there is any hardware in DHW, ITSD will be involved. Dick Schultz requested that ITSD have a consulting role in selecting software. The Committee asked the Bureau whether there was a benefit of a particular choice. Several of the vendors are very familiar with web-based databases and security issues. Outsourcing to a web based technology provides real time information, and wide spread availability. Dick Schultz stated a concern with putting all our resources "in one basket" because the contractor has control and can raise prices. This would be the first time DHW has done this kind of a contract. The Committee suggested an RFP for a contractor to provide management, support, and selection of appropriate software. John Cramer addressed the advantage of moving all data from previous registries into the new database. He informed the Committee that data in different formats is nearly impossible to combine for analysis and reporting purposes. Extraction of data will be more efficient and user friendly once all data is in the registry. Several vendors indicated that they could seamlessly interact with the existing "National Trauma Registers of the American College of Surgeons" (NTRACS) hospital systems. This is a business requirement in the RFI. The Idaho Trauma Registry has a smaller	

	data set than the national database. Hospitals will be encouraged to continue to submit a larger data set to the national registry. Advantages of using a web-based system were discussed. • The state has liability for paying hospital costs. The implementation and upgrade of hardware, software, training, and operation can be costly. A web-based program wouldn't have these issues and is therefore attractive from a cost management view. • Transfer of old files from a database has a price tag, but is claimed to be seamless as a one time export. Then after this data is transferred, all data entry will be direct on the web. • The web program can accept the larger data set from hospitals. Dia Gainor suggested that the web-based trauma registry could be used by hospitals who are dissatisfied with their current systems. • Vendors have indicated that there is unlimited capacity to add new fields to accommodate various hospital database customizations on the web based system. Other issues to be considered: • Security of specific patient names and information for HIPPA requirements. • Still need to be interested in the costs of other options to be fiscally responsible. Bob Seehusen suggested that if the subcommittee finds that a web based concept is workable for hospitals (based on the findings of the task force chaired by Lynette Sharp) that we do outsource a web based program.	

POTENTIAL FUNDING SOURCES (STATE MOTOR VEHICLE REGISTRATION FEE)	Concept of using a motor vehicle related fee to fund the registry came up at the last TRAC meeting. Based on historical data that has remained fairly level for 14 years, the Bureau postulated a $.25 and a $.50 fee increase to determine potential funding for operational costs of the registry. Projections of funding that could be expected from either fee increase were distributed to Committee members. They agreed it is logical to tie the trauma registry costs to motor vehicles because the Idaho Transportation Department (ITD) has data about motor vehicle crashes, but they don't have data on the effects of the trauma on patients and associated costs. In order to reduce objections of legislators to this proposal, it was agreed that current funding received by DHW of $1.25 from each motor vehicle registration should be examined and re-evaluated. Reporting the justification and use of current funds would also be an excellent argument to convince legislators that current funds are being used judiciously and funding is necessary for the registry to achieve implementation. Dr. Sturkie asked if we would be adding to the current EMS I & II fund category or creating a new category. The Committee agreed there would be more flexibility to use excess funds for other EMS operations if it is added to the current EMS II dedicated category. This may be more appealing to legislators. Should the request for an increase of drivers license fees fail, it may be necessary to redistribute current funding from the EMS I & II dedicated funds collected from motor vehicle licensing and drivers license fees used for non-mandated operations toward the funding of the registry. Could the Bureau redirect the agency training grant? Dia Gainor clarified that these are general funds. The Bureau will continue	**Decision points** Administratively identify funding resources that are currently available. Next legislative session (2005) • Look at potential of a shift of dedicated funds. • Change the intent language of the current legislation to allow using dedicated/general funds. • Address sunset legislative issues.

	to look for appropriate grant opportunities, but grant funding is not generally awarded for operational purposes and can be eliminated at any time, making it a risky source of funding. The 2005 legislative session will be the opportunity to change the intent language of the current legislation to allow using dedicated/general funds for the trauma registry and address sunset legislative issues.	
DEVELOPMENT OF DRAFT RFP	The current available development funding resources totals $326,000 comprised of the following: $ 40,000 HRSA – Trauma 188,000 OHS (development, infrastructure) 100,000 St. Alphonsus RMC 98,000 HRSA – EMSC $ 326,000 DHW will provide information about current usage of motor vehicle registration funding and the life of current federal grant and other potential funding at the next meeting. There was some confusion within the Committee about the terms that were being used (contractor, vendor, systems manager) that required further clarity before the discussion could continue in a productive manner. **Vendor**: Software provider **Contractor**: Systems manager Discussion followed regarding timing of a Request for Proposal (RFP) based on the RFI results and discussions at today's meeting. Bob Seehusen suggested that by developing an RFP immediately, we would have an idea of costs for requesting operational funds. Asked whether there can be a contingency in the RFP that it is dependent on appropriate legislation. Dick Schultz replied that the RFP is very specific about time limits to respond. Starting an RFP would incur	Bureau will provide information about current usage of motor vehicle registration funding. Bureau will provide data about life of current federal grants and other potential funding. Motion that we select a contractor who will provide a web based system. Seconded. Carried. Motion to select a web-based contractor and allow the contractor to manage the selection of vendor. Seconded. Carried. Steve Millard abstained from voting. Next steps are: • Develop a product needs list. (Requirements process and outcomes from the CTQ and hospital end user outcomes) • Determine contractor selection process. • Select the contractor with RFP. • Select pilot hospitals. • Pilot vendor products as advised by the contractor.

	expense for potential vendors and we need to be prepared to proceed once we send the RFP for bid. Hospitals will also be committed when they make the change. We need to assure them that the system will be maintained and continued. NTRAX got into major hospitals because of a federal grant to St. Alphonsus RMC. Now that funding has been withdrawn, the hospitals have had to pick up the costs. The Committee agreed not to put the hospitals into a similar situation by introducing a registry to them for testing that has not been adequately piloted and funded. Dick Schultz suggested that the Committee will only be able to determine hospital costs experientially by piloting the system. Hospital costs for the registry are outside of the contract costs with a system manager. Determining hospital costs could only occur by conducting a pilot of the software chosen by the contractor. Schultz is leaning toward a level reimbursement rather than a per unit rate, but the pilot will determine the feasibility of that approach. There were concerns about the time required to conduct a pilot with regard to the specific completion dates in statute. A pilot could be done administratively in time to have estimates on the cost of a registry for the 2005 legislative session. A summary of the benefits of piloting the software are: • Short term – evaluation of the product before awarding the bid. • Long term – 1) satisfaction with product 2) determining costs. The Committee reached consensus that an initial limited RFP should be used as a mechanism to conduct a pilot of the software and the performance expectations with the contractor. How do we determine the support and	The RFP process requires the contractor to use business and software requirements as a basis of selection. Target date of January 2005 for the pilot.

	management abilities of a contractor when piloting or evaluating the software? TRAC needs to clearly define what "managing" means and what it will encompass. John Cramer presented a flow chart showing two scenarios for selecting a system. 1) Select a contractor 2) Select software and then the contractor and vendor submit a pilot proposal. The Committee suggested and agreed on a third option: **3) Pick a contractor who will then select an internet software vendor.** Next steps are: • Develop a product needs list. (Requirements process and outcomes from the CTQ and hospital end user outcomes) • Determine contractor selection process. • Select the contractor with RFP. • Select pilot hospitals. • Pilot vendor products as advised by the contractor. The Committee suggested a pre-trial period to select the product, then a longer (year) time to use the product that would be a requirement of the RFP. It might be necessary to pre-trial a proxy generic product that would not be Idaho specific. Will the contractor implement, manage pilot, and assess costs? How are we going to evaluate the most cost effective method or system? Dia Gainor stated that the contract would set up a measurement system to assure evaluation of the most cost effective method or system. Dick Schultz stated that the RFI respondents may not willing to extract data and do data	

	entry and payroll hospital costs and then wait for reimbursement from the state. Dia Gainor proposed that the subcommittee chaired by Lynette Sharp who is convening a group of experienced registrars and end users could start a needs list. Chris Leeflang suggested visiting current users to evaluate the product. Site visits would provide additional information about state or national verification processes. Dick Schultz suggested pursuing rules promulgation when on-going funding, cost estimates, and a year's experience in the pilot is completed. A minimum of six months of collecting fees would be required to have a pool of money.	
HOSPITAL ADMINISTRATOR MEETING	To fulfill the requirements of the Trauma grant, the EMS Bureau is required to make a presentation to hospital administrators about the trauma registry progress. The Bureau will introduce the trauma registry project to Idaho Hospital Association (IHA) conference meetings in June and October.	The Bureau will introduce the Trauma Registry project to IHA.
SET NEXT AGENDA AND MEETING DATES	1) Hospital Trauma Registry Subcommittee results – Lynette Sharp 2) Dedicated Funds Report 3) Grant Funding amounts and the life. RFP Status Report	Friday, July 9, 2004